



Plan Year  
2015-16

Employee #: \_\_\_\_\_ Name (Last, First, MI): \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State Zip: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Phone: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_  
(Cell) \_\_\_\_\_ E-mail Address: \_\_\_\_\_

## HEALTH SAVINGS ACCOUNT (HSA) CONTRIBUTION CHANGE FORM

### EFFECTIVE DATE OF CHANGE

- You may change your payroll-deducted personal contribution to your HSA monthly
- The Benefits Office must receive your completed form by the 15<sup>th</sup> of the month for your change to be effective the first of the following month with one exception:
  - HSA Contribution Change Forms received during June will become effective August 1<sup>st</sup> – All changes effective July 1<sup>st</sup> must be made during Open Enrollment via the online enrollment system
- Change requests received after the 15<sup>th</sup> of the month will be effective the first of the second month following date of receipt
  - *Example 1:* The Benefits Office receives your form any time between August 1 – 15 → Your change will be effective September 1
  - *Example 2:* The Benefits Office receives your form any time between August 16 – 31 → Your change will be effective October 1

**Please change my biweekly contribution amount to: \$ \_\_\_\_\_**

**Minimum to participate is \$1.00. Maximums are as follows:**

	<b>Under 55</b>	<b>55 and Older</b>
<b>Single</b>	\$90.38	\$128.84
<b>Family</b>	\$178.84	\$217.30

I have received and read the materials explaining my City benefits. I understand that by signing and submitting this form, I am making an election concerning my benefits for the plan year ending **June 30, 2016**. This election is binding, subject to my right to make changes according to the provisions of the program and subject to changes required to comply with state and federal laws. This Election Form is not an employment agreement.

I hereby certify that the above information is true and correct to the best of my knowledge.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**Please return this form to:**

*City of Tucson Benefits Office*

255 W. Alameda, 3<sup>rd</sup> Floor, PO Box 27210, Tucson, AZ 85726

**Phone:** 520-791-4597 **Fax:** 520-791-5942 **E-mail:** [benefitquestions@tucsonaz.gov](mailto:benefitquestions@tucsonaz.gov)

#### **BENEFITS OFFICE USE ONLY:**

Effective Date: \_\_\_\_\_

☐ HRM

☐ Buck

Rev. May 27, 2014